TELEPHONE ASSISTANCE PROGRAM (TAP) – APPLICATION FOR THE MEDICALLY NEEDY

Please Read All Instructions Before Completing

In order to be eligible for the TAP discount program, there must be a medical need for a telephone in the household and be at or below the federal poverty guidelines indicated in the income chart below. The medical confirmation form included with this application must be filled out and returned with this application.

Please respond completely. Inaccurate or incomplete responses may cause your application to be rejected. The information on this application will only be used to assess your eligibility for TAP Assistance.

PLEASE NOTE: for the purposes of this form, the TAP program will be referred to as Lifeline.

Telephone Number		Existing Account #	
First Name	MI	Last Name	
Address Where Service Is Located (No PO Boxes)		City	State
This is my permanent address: yes ☐ no ☐		Zip Code	
Billing Address, City, State & Zip Code (If different from Service Address) (PO Boxes Allowed)			
Social Security Number		Or Last four digits of Tribal Identification Number	
Date of Birth	Disabled: yes ☐ no ☐	Homeless: yes ☐ no ☐	
Application Date		E-Mail Address	
DES/AGENCY USE ONLY			
Worker I.D. No.	Site Code	Serial No.	

INCOME GUIDELINES: PLEASE CHECK the corresponding box on the income chart and fill in actual household monthly income below. Please indicate the number of household members if more than 5.

Number in Household	**TAP 150 % of Federal Poverty Level**
1 ☐	$16,755
2 ☐	$22,695
3 ☐	$28,635
4 ☐	$34,575
5 ☐	$40,515
For each additional household member add	$5,940
Number of household members greater than 5: _____	Actual Household Monthly Income: $_____

HOUSEHOLD INFORMATION				
Social Security Number	**Name (Last, First, M.I.)**	**Gender**	**Date of Birth**	***Ethnic Code**
APPLICANT 1.		☐M ☐ F		
HOUSEHOLD MEMBER 2.		☐M ☐ F		
HOUSEHOLD MEMBER 3.		☐M ☐ F		
HOUSEHOLD MEMBER 4.		☐M ☐ F		
HOUSEHOLD MEMBER 5.		☐M ☐ F		
HOUSEHOLD MEMBER 6.		☐M ☐ F		
HOUSEHOLD MEMBER 7.		☐M ☐ F		
HOUSEHOLD MEMBER 8.		☐M ☐ F		
HOUSEHOLD MEMBER 9.		☐M ☐ F		
HOUSEHOLD MEMBER 10.		☐M ☐ F		

***Ethnic Codes**

White	1
Black	2
Native Amer.	3
Hispanic	4
Asian	5
Other	6

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF AGING AND ADULT SERVICES

TELEPHONE ASSISTANCE PROGRAM (TAP) - Medical Confirmation Form

The Department of Economic Security, Corporation Commission and CenturyLink are jointly administering a telephone assistance program in the state of Arizona. The program provides assistance for low income persons with a medical need. The application process is being conducted jointly by the Department of Economic Security and local volunteer agencies. The program provides for the monthly basic rate, and assistance with installation costs if needed. We are asking for your assistance in the determination of medical need in order for the household to qualify for this benefit.

DOCTOR'S OFFICE USE ONLY
CONFIRMATION OF MEDICAL NEED

Patient's name | Phone no.

Patient's address (No. Street apt#)

(City) | (State, ZIP)

Patient's Signature | Date:

The patient has a medical condition that would require a telephone in the household. The medical condition will require the availability of a telephone for approximately:

☐ Up to one year ☐ Two years or less ☐ Three years

Doctor's Name | Phone no.

Doctor's Address (No., Street)

(City) | (State, ZIP)

Doctor's Signature | Date:

DES, FAMILY SERVICE CENTER OR COMMUNITY ACTION PROGRAM (CAP)
AGENCY USE ONLY

YES	NO	
☐	☐	The home is wired for telephone service.
☐	☐	Has the household had land-line telephone service in the past 90 days?
☐	☐	The doctor's signed statement indicates applicant's medical need.
☐	☐	The doctor's signed statement indicates applicant's medical crisis.

The medical need will last *(Check appropriate box)*
☐ Up to one year ☐ Two years or less ☐ Three years

YES ☐ NO ☐ Is the caseworker providing certification for TAP? **(Worker Certification is only valid for 1 year)**

Worker's Signature | Date:

If you have any questions regarding this form, please call the TAP office at 542-4446 or 1-800-582-5706.
THIS FORM IS ONLY VALID FOR 60 DAYS AFTER THE DOCTOR'S SIGNATURE DATE.
PLEASE INCLUDE THIS FORM WITH YOUR APPLICATION.

07/05/12

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION ABOUT THE TAP/LIFELINE PROGRAM BEFORE YOU SIGN BELOW:

- **Lifeline is a federal benefit and willfully making false statements to obtain the benefit can result in fines, imprisonment, de-enrollment or being barred from the program.**
- **Only one Lifeline service is available per household. A household is defined for the purposes of the Lifeline program as any individual or group of individuals who live together at the same address and share income and expenses.**
- **A household is not permitted to receive Lifeline assistance from multiple telephone service providers. This includes both wireless and wireline providers.**
- **Violation of the one-per-household limitation constitutes a violation of the Federal Communications Commission's rules and will result in the subscriber's de-enrollment from the program and potentially prosecution by the US government.**
- **Lifeline is a non-transferable benefit and the subscriber may not transfer his or her benefit to any other person.**

PLEASE READ AND INITIAL THE FOLLOWING:

I certify, under penalty of perjury, that:

_____ • I understand and consent to CenturyLink providing my Lifeline service account information, including but not limited to, my name, residential address, phone number, date of birth; the last 4 digits of my social security number; the date on which my Lifeline service was initiated/terminated, the amount of Lifeline support provided, and the means through which I qualified for Lifeline, to the Universal Service Administrative Company (USAC), USAC's agents and/or the National Lifeline Accountability Database to ensure the proper administration of the Lifeline program. I understand that if I fail to provide this consent, CenturyLink will deny me Lifeline service.

_____ • I understand that if I am identified as receiving more than one Lifeline benefit, all telephone service providers involved may be notified so that I may select one service and be de-enrolled from the other(s).

_____ • My household meets the program-based or income-based eligibility criteria indicated above.

_____ • I must notify CenturyLink within 30 days if for any reason my household no longer satisfies the criteria for receiving Lifeline assistance. This includes if I no longer meet the income-based or program-based criteria for receiving Lifeline support, if I am receiving more than one Lifeline benefit, if another member of my household is receiving a Lifeline benefit, or for any other reason, my household no longer satisfies the criteria for receiving Lifeline support. Failure to notify CenturyLink may result in penalties and deenrollment from the program.

_____ • I must notify CenturyLink within 30 days if I move to a new address.

_____ • Only one Lifeline service benefit is available per household. To the best of my knowledge, my household is not already receiving a Lifeline service.

_____ • I understand that my CenturyLink Lifeline service is not transferrable. I may not transfer my service to any individual, including another eligible low-income consumer.

_____ • I understand that providing false or fraudulent information to receive Lifeline assistance is punishable by law.

_____ • I understand that I may be required to re-certify my household's eligibility for Lifeline assistance at any time, and if I fail to re-certify as to my continued eligibility, it will result in de-enrollment and the termination of my household's Lifeline assistance.

_____ • The information contained in this form is true and correct to the best of my knowledge.

_____ Date: _____

Telephone Assistance Program Applicant Signature
(Must be the same name as on page one)

Please mail this completed application and any supporting documents to:
Arizona Department of Economic Security –
Division of Aging and Adult Services
Practices Lifeline Telephone Discount Program – 950A
P.O. Box 6123
Phoenix, AZ 85005-6123

For answers to questions concerning TAP,
Please call DES-DAAS at 1-602-542-4446
or 1-800-582-5706

Application Checklist – Please provide the following:

1. Signed and completed TAP application form
2. Proof of income for the past 30 days
3. Verification of Social Security Numbers for all adult (over age 18) household members
4. Confirmation of Medical Need form signed by a doctor, establishing a medical need

If there are multiple unique households (as defined in question 1) at your address, please also complete and submit the Household Worksheet below. This will assist us in being able to respond promptly to your request for Lifeline benefits.

1. At some addresses, there are multiple unique households. A household is defined as a group of individuals who live together, at the same address, and share income and expenses. For example, apartments in an apartment building are usually unique households. Individuals living in a nursing home can be considered unique households. Are there adults living at your address who are **not** part of your household?
   _____**YES** _____**NO**

   - If you checked **YES**, please read and initial line A in the certification box below. Then, continue to question #2.
   - If you checked **NO**, please continue to question #2.

2. In addition to yourself, are there individuals living at your address who are part of your household? This could include your spouse, domestic partner, an adult relative, or a roommate. _____**YES** _____**NO**

   - If you checked **YES**, please continue to question #3.
   - If you checked **NO**, you do not need to answer the remaining questions. Please read and initial line B in the certification box below, and sign and date the worksheet.

3. Do any members of your household, including you, currently receive Lifeline discounts on a wireline or wireless phone?
   _____**YES** _____**NO**

   - If you checked **YES**, your household is not eligible for another Lifeline discount. Please do not submit this application. If the other Lifeline discount(s) are discontinued, you may submit an application at that time.
   - If you checked **NO**, please initial line B below, and sign and date the worksheet and mail it back.

CERTIFICATION

Please initial the certifications below based on your answers to the three questions above, sign and date this worksheet

A. ____ *I certify that I live at an address occupied by multiple households.*

B. ____ *I understand that violation of the one-per-household requirement is against the Federal Communication Commission's rules and may result in me losing my Lifeline benefits, and potentially, prosecution by the United States government.*

Signature_____ Date_____

[1] A household is defined, for the purposes of the Lifeline program, as any individual or group of individuals who live together at the same address and share income and expenses.